move once to twice a day. He has no abdominal discomfort and no sign of recurrence.

COMMENT

Billroth in 1869 reported the first case of multiple carcinomas. Regarding the incidence of these as independent lesions he laid down three postulates: (1) The two growths must have distinct histological differences. (2) Each growth must spring from its parent epithelium. (3) Each growth must be held responsible for its own metastatic growths.

Christian Fenger before the Chicago Gynæcological Society in 1888 reported one of the earliest cases of double carcinoma of the colon, a carcinoma of the ascending colon and one of the splenic flexure. Rankin[1] in reviewing a large number of cases says that the incidence of multiple carcinomas is very small. Major, in his review of the literature, reported 196 different combinations of malignant lesions in as many patients between 1889 and 1918. In this series not more than one tumour of the colon occurred. Ewing in his 1928 edition of "Neoplastic Diseases" says: "We do not speak of recurring uterine myomas for these are clearly multiple, so why not carcinoma and sarcoma?" Schweiger and Bargen[2] say:

> "(1) Transplantation of carcinoma in the large bowel from one site to another is extremely rare. (2) Transplantation by way of the lumen would fail entirely to explain these cases in which the proximal growth is smaller than and far separated from the distal growth. (3) Mucus secreted in the large bowel, the peristaltic activity of the bowel and the force of the fecal stream would not allow the cells cast off at one growth to grow at a distal site. Implantation of carcinoma cells no doubt occurs at some sites, notably in cases of Krukenberg's tumours of the ovary but this is not the correct explanation for the multiple growths in the large bowel. Robertson, after an extensive experience, has remarked that carcinomatous transplantation in the large intestine must be extremely rare."

However, J. Silvers[5] says about Billroth's postulates:

> "Most authors agree these postulates are too strict or are impossible to apply accurately to all types of neoplasms. When growths arise from the same organs, or originate in the same tissues, and are of the same type, then the histological picture must be about the same. . . ."

G. V. Brindley[6] speaking of Billroth's postulates states:

> "It is difficult, if not impossible to differentiate histologically many primary lesions. Could a Grade II malignancy of the ascending colon be distinguished from a Grade II lesion of the transverse?" The same author does not consider broken off fragments of cancer easily implanted on a smooth mucous membrane. "Metastasis is not regarded as a basic criterion because it is too variable as to incidence and cell appearance."

Warren and Gates in their individual series of 1,078 cancer autopsies found only two instances of multiple foci in the large intestine. Bargen and Rankin[1] registered 16 such cases, the largest individual group. Second only to this are the reports of four patients each by Lockart-Mummery and Cakkins, of authentic cases in which both growths are limited to the colon. Cakkins in 1932, found only 29 in the literature and reports four additional cases of his own. It is difficult to understand how one growth can be metastasis from the other when no other metastases in the glands were found and when the distal growth was larger in size than the proximal one.

In conclusion a word of advice to us general practitioners who have to do general surgery is to examine carefully the whole field when the abdomen is open. Many may be the surprises in Pandora's box!

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SPECIAL ARTICLE

THE GENERAL PRACTITIONER OF TODAY*

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I wish to speak of general practice and its problems. I have been twenty-five years preparing this little speech, for during that time in Western Ontario along the shores of Lake Huron—"La Mer Douce" to Champlain 330 years ago—I have been partly responsible for the medical care of some 3,000 persons.

Some conclusions are very clear to me. I am well aware that the whole panorama of medical practice is changing rapidly. As a part of this, specialized practice is advancing by leaps and bounds. In attempting to bring the best of medical care to my people, I have come to look upon specialists as having three functions to perform. First, they are consultants and as such they help to keep me out of

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trouble, or to get me out of trouble. The older and wiser I get—the latter may be an illusion—the more frequently do I desire consultation. Secondly, they are my teachers, and all that I am I owe to them. Thirdly, they are our research workers. Within my horizon I believe there are fair deductions.

General practice encompasses the art and science of medicine in the diagnosis and treatment of 85% of the ills of mankind, and this includes the knowledge of when and where to obtain help for the remaining 15%. It is not something that is left after the specialties have been skimmed off, but a field worthy in its own right. It too is changing or ought to change. To aid in keeping pace with increasing medical knowledge and with social changes the general practitioners of Ontario felt the need for an organization of their own. We have now a section of general practice within the Ontario Medical Association. This is not divisive but is another root through which the parent plant can derive nourishment. What I give you today is largely some of the conclusions of this section in so far as it has become vocal.

We cannot see far into the future. We do not know what medical practice will be like even fifty years hence, but we can best protect ourselves and prepare for it by a close study of the present, and repair any defects we find. The doctor who is most concerned about the future of medical practice is not you or I. It is the senior medical student and the recent graduate. I feel sure of this after meeting several of these groups including those of Western University at London recently. This may interest you. In 1946 only 12% of the graduating class of the Medical School of the University of Toronto expressed a preference for general practice. This year in that school 58% so stated their preference. That is a challenge to us, their seniors, to assure them that twenty years from now they will have little cause to regret their choice. Many family physicians feel that they will regret it if we do not bestir ourselves.

The general physician today is holding a central and vital part in providing for at least 75% of the medical care of our people. He does not hold a similar and vital part in the training of doctors. More and more emphasis has been placed on the training of specialists. We have no quarrel whatever with this *per se* but must strenuously assert that there should be a comparable emphasis on training for general practice. We have drifted into an attitude whereby the student who wishes to specialize must submit to thorough and rigid rules of training, and have given much less thought to the regulations governing the training of a good family physician. I submit that his work is just as important and just as difficult.

A recent report on the medical curriculum by a committee of the British Medical Association (1948) states:

> "General medicine should be taught as the basic clinical subject. What is needed is the sense of unity in medicine. Linked with this is an appeal for the renaissance of the general physician. One of the primary reforms should be the return of the physician with the general outlook. It is he who should be the co-ordinator of medical teaching and the prevailing influence in the medical school."

We believe that each university should have a chair of General Practice and that general practitioners should be made thoroughgoing and integrated members of medical school faculties. We know of no better way of obtaining in teaching schools a really adequate total-person approach to the ills and injuries that beset mankind. We know of no better way for a wholesome counterbalancing of the enthusiasm of specialists teaching in their particular fields of work. We know of no better way of making the family physician feel as he goes out into the world that he is as important a cog as any other in the complicated machine of modern medicine.

A high standard of modern medical practice requires that every effort be made to make available hospital facilities to every practitioner. Every doctor on hanging out his shingle should be welcomed at his neighborhood hospital and given some standing on its staff, if only a courtesy standing as the first rung of a ladder of merit that he may climb. The barring of hospital facilities, either in policy or in fact, to the general practitioner is undesirable and must be opposed. The only way men can become competent and efficient is by being allowed to use and extend their knowledge and techniques. To reduce the family physician to the status of a selector of specialist services or a sort of director of traffic will make him less competent and will repel capable men from this field. Some of the most brilliant medical educationalists in the United States feel this. Dean Schwitalla of St. Louis Medical School states that he unreservedly and uncompromisingly favours the finding of a place for the general practitioner on the staffs of all city and University hospitals. The continued use by some city hospitals of the all-too-convenient yardstick of certification in making staff appointments makes it necessary to obtain certification of competent general practitioners.

At the postgraduate level we believe we should make specialization possible for those family physicians who desire it. We feel that it should be possible for him to get a certificate or diploma that he is especially competent in a particular field, or as a family physician. In Canada there are only eight centres where training is available for preparation for fellowship standing. We are not suggesting any

lowering of the standards for this or for certification by the Royal College, but feel that there is need for an intermediate group between these and the general practitioner. To this end in each specialty there might be a prescribed course of reading with examinations when this is completed. If successful in this there might be a further course of lectures and practical instruction in the specialty. At the end of such a course he could be permitted to stand for examination for certification or a diploma for competency either in a specialty or for general practice. It is becoming very difficult for a doctor after some years in general practice to get back on the assembly line aiming at specialization. It is becoming too true that once a general practitioner always a general practitioner.

In this period of transition and change in medical practice we feel very strongly that group practice is one answer for many of our problems. It allows for better working conditions and more time for postgraduate studies. Also, by the pooling of resources and knowledge we can give better service at a lower cost to our patients. We intend to give our doctors all the information we can on partnership and group practice.

The family physician has many opportunities for doing first-rate clinical research. Studies might be undertaken on the environmental influences on disease; the beginnings, course or end results of many chronic illnesses; or nutritional problems—the list is endless. We propose to make a start in this manner. The pædiatricians have been asked to choose three subjects for study. They have chosen the anæmias and the diarrhœas of infancy and convulsions in childhood. They are preparing questionnaires and bibliographies on each of these and they will be ready next month, and any doctor who wishes to participate in the study can write in and procure them. At the end of a year it is proposed to invite all the doctors who contributed to the study to meet with the specialists who prepared it and review the information submitted. The specialists in internal medicine, surgery and obstetrics are preparing similar questionnaires on problems in their fields. We are convinced that the carrying out of clinical research by a controlled plan such as this will improve the practice of medicine and will enrich the life of the professional man who does it.

These are some of the measures of which we are thinking and they are designed to improve the calibre of practice of the family physician by making him a better diagnostician and a more useful citizen. If we can do this many other desirable things automatically will be added unto him. In all this it is my firm belief that what is best for the family physician is best for the whole of the medical profession.

CLINICAL and LABORATORY NOTES

A MULTI-HOLED URETERAL CATHETER*

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It is not very probable that the present state of our diagnostic ability is going to improve much in the field of the more common genito-urinary diseases. The proper interpretation of symptoms, of laboratory findings, and of x-ray studies provides a very high incidence of correct diagnoses. However, it does seem that a multi-holed ureteral catheter which would allow the ureter to be filled with opaque media at the same time that the kidney pelvis is being filled following cystoscopic examination, presents some diagnostic advantages not obtainable with the present type of catheter. An x-ray film is thus made of the entire tract at the same time. This has two principal advantages, namely, (1) the obviating of a repeat catheterization if the first pictures, as made with a single hole catheter during its withdrawal, are not satisfactory, and (2), the find-

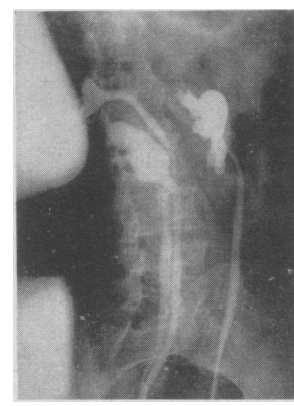

Fig. 1

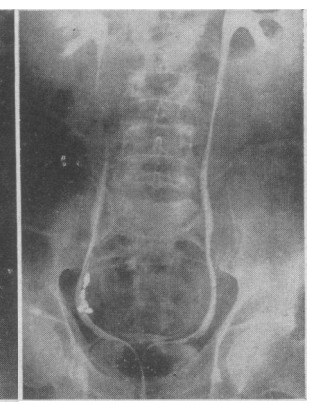

Fig. 2

Fig. 1.—Lateral-oblique retrograde pyelograms made following cystoscopic examination. The catheters were unfortunately partly pulled out before the picture was taken. However, the ureters had been filled through the multi-holed catheter. Their clear and normal outline was of great importance in the differential diagnosis of abdominal pain. One of the double ureters on the right side would probably not have been seen as well if the dye had been injected through the "single-hole" catheter in one pelvis only. **Fig. 2.**—Usual retrograde pyelograms made following cystoscopic examination. A negative shadow is seen in the distal end of the left ureter. The heavy shadow in the right pelvis is thought to be the appendix, because it changed position following manual compression of the abdomen. The medium causing the shadow is unknown.

* Appreciation is expressed to Mr. F. J. Wallace, The American Cystoscope Makers, Inc., through whose kindness these catheters have been manufactured.